STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Michigan

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND
SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

1. **INPATIENT HOSPITAL SERVICES** (other than services in an institution for tuberculosis or mental disease) when furnished by a certified hospital under the direction of a physician.

   a. Covered Services: All admissions must be necessary for the physicial or mental health of the patient and must be made upon the direction of a physician.

   10/01/90 | Prior approval from the Medical Services Administration or its designated contractor is required for elective* admissions. Admissions to a state-owned psychiatric hospital do not require this approval.

   For admissions to a separate inpatient unit which, under contract with the Michigan Department of Mental Health, provides inpatient hospital services to youth who are enrolled in a special program for those who are both developmentally disabled and emotionally impaired, prior approval from the Michigan Department of Mental Health is required for elective* admissions and readmissions.

*"Elective" is defined as a condition that is neither an emergency nor an urgent condition. "Emergency" is any condition for which a delay in treatment may result in the recipient's death or permanent impairment of health. "Urgent" is an acute condition, not as serious as an emergency, yet one in which medical necessity dictates a hospital environment.

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Prior approval from the Medical Services Administration or its designated contractor is required for all readmissions within 15 days. However, if the admission was to a state-owned psychiatric hospital, approval is only required for the readmission if it is elective and to a facility not owned by the state.

Prior approval from the Medical Services Administration or its designated contractor is required for elective transfers between hospitals. Urgent or emergent transfers require approval immediately following the transfer. Such approval is not required if the transfer is to or from a state-owned psychiatric hospital.

Claims will be reviewed by the Medical Services Administration or its designated contractor on a pre- or post-payment basis to assure the medical necessity of admissions, transfers, and readmissions and the appropriateness of diagnosis and procedure coding. Claims requesting outlier reimbursement will be reviewed for appropriateness by the Medical Services Administration or its designated contractor.

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Inpatient hospital benefits in a freestanding rehabilitation hospital are limited to thirty (30) days per admission unless medical necessity dictates an extension beyond the benefit limitation. Hospitals must obtain approval from the Medical Services Administration or its designated contractor for inpatient stays which exceed thirty (30) days. An additional approval must be obtained for inpatient stays which exceed sixty (60) days.

Admission authorization and continued stay review authorization from the Medical Services Administration or its designated contractor is required for an Inpatient Hospital stay in a freestanding psychiatric hospital or a Medicare-certified distinct-part psychiatric unit of a general hospital. For elective admissions, admission authorization is required prior to admission, and for urgent/emergent admissions, authorization is required within one working day.

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Payment will not be made for services of staff in residence, e.g., interns and residents, or medical staff functioning in an administrative or supervisory capacity (including physician-owners) who are paid by the hospital or other sources.

*"Elective" is defined as a condition that is neither an emergency nor an urgent condition.
"Emergency" is any condition for which a delay in treatment may result in the recipient's death or permanent impairment of health.
"Urgent" is an acute condition, not as serious as an emergency, yet one in which medical necessity dictates a hospital environment.

Services Included in DRG Calculation/Payment

All routine services (e.g., room and board, nursing) are included in the DRG payment.

All diagnostic services (radiology, pathology, etc.) are included in the DRG payment.

Diagnostic services that are performed at a second hospital because the services are not available at the first hospital (e.g., CT scan) are included in the first hospital's DRG payment. Arrangements for payment to the second hospital where the services were actually performed must be between the first hospital and second hospital.

All pathology services that are performed by the pathologist but do not relate directly to a specific recipient's care are included in the DRG payment.

Anatomic pathology services provided directly by the pathologist are not included in the DRG payment. If the pathologist who provides these professional services is employed by the hospital or directly contracts with the hospital, that pathologist must also enroll as a Medicaid provider for separate payment to be made. Medicaid's fee-for-service policy applies to pathologists.

All ancillary services provided by the hospital or performed by another entity (e.g., hospital having a contractual agreement with an enrolled independent laboratory) are included in the hospitals' DRG payment. EXCEPTION: Ancillary services provided by a hospital enrolled with Medicaid as a separate Medicaid provider code are excluded from the DRG payment.

All emergency room services provided by the hospital resulting in an inpatient admission are included in the hospital's DRG payment.

NOTE: The above list is not inclusive.

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Services Excluded from DRG Calculation/Payment

Hospital-based professional services are excluded from the DRG payment.

Services provided by a nurse-midwife are excluded from the DRG payment.

Services provided within the scope of their profession by registered nurses certified by the Council on Certification of Nurse Anesthetists or recertified by the Council on Recertification of Nurse Anesthetists are excluded from the DRG payment.

Ambulance services for recipients who are transported to a second hospital for diagnostic services are excluded from the DRG payment.

If a service is excluded from the DRG payment (e.g., ambulance, nurse-midwife), that service may remain a covered benefit. Since the service is not included in the hospital's DRG payment, that service must be separately billed by that enrolled provider. Separate reimbursement for covered services is then issued when the services are billed using the correct provider ID Number and the appropriate claim form.

NOTE: The above list is not inclusive.

The Specific Items of Services Covered are:

Bed and board, including special dietary services in a semi-private room, or if medically necessary, in a private room as ordered by the attending physician.

Medical, obstetrical, surgical, and anesthesiology services, including use of operating room, delivery room, etc.;

Drugs and medicine;

Laboratory services when specifically ordered in writing by the attending physician or other responsible practitioner (e.g., consultant, intern) for a specific recipient.

Radiology services including x-ray, radium, radioactive isotopes, etc., when specifically ordered in writing by the attending physician for a specific patient.

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General nursing service incidental to the care and treatment of the patient.

Whole blood (when not available from other sources).

Other items and services ordinarily provided by the hospital for the care and treatment of inpatients.

The use of all prosthetic and surgical appliances and any other equipment essential to the treatment of the patient.

10/01/94

Physical therapy services must be either restorative or specialized maintenance programs to be covered. Physical therapy must be ordered by a physician, in writing. Services must be provided by a physician, physical therapist, or physical therapy assistant or aide under the supervision of a physical therapist. A treatment plan must be developed and identify the individual modalities to be employed and how they relate to the condition being treated. Each restorative plan must include the expected results of the therapy and the time frames needed to achieve those results.

Inpatient occupational therapy services of a restorative nature, ordered in writing by a physician, are covered. Therapy services must be performed by a registered occupational therapist, or a certified occupational therapy assistant under the supervision of an occupational therapist.

Inpatient psychiatric occupational/recreational therapy is covered when ordered in writing by a physician as part of the recipient's active psychiatric treatment plan. It must be provided by a psychiatrist, an occupational therapist, or an occupational therapy assistant under the supervision of the occupational therapist, in a psychiatric hospital or a psychiatric unit of a general hospital.

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Speech therapy services must be restorative and ordered in writing by a physician to be covered.

1) services for recipients over age 21 do not require prior authorization. Services must be rendered by audiologists who have a Certification of Clinical Competency.

2) Inpatient speech therapy services provided to recipients under age 21 (subject to the same limitations as for recipients over age 21) require prior authorization. Services are covered only when provided by hospitals having an enrolled hearing and speech center or having a contractual agreement with an enrolled hearing and speech center.

Substance Abuse Services

If a hospital has a sub acute substance unit, that unit must meet the requirements in Attachment 3.1-A, pp. 26, 26a, 13(d) 1 to receive reimbursement for the services described in that section.

If acute care detoxification is warranted, it will be covered. However, once the recipient's condition is stabilized, he or she must be referred to an appropriate treatment service.

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b. Excluded Services

The specific items or services excluded are:

Services of special nurses.

All personal comfort or convenience items, e.g., telephone, radio, television, etc.

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Occupational therapy provided for educational, vocational, or recreational purposes.

Speech therapy provided for educational, vocational or recreational purposes. Speech therapy when another public agency can assume the responsibility of the service for the recipient.

Laboratory services when performed as routine procedures, e.g., because of existing hospital policy or attending physician's standing orders.

Radiology services when performed as routine procedures, e.g., because of existing hospital policy or attending physician's standing orders.

Certain selected surgeries, as specified by the MA program, that may be performed on an outpatient basis, unless there are medical factors that contraindicate the performance of the procedure on an outpatient basis.

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All of the following if the primary reason for admission was to receive one or more of these services:

1) observation.
2) diagnostic procedure which can be performed on an outpatient basis.
3) physical, occupational, or speech therapy.
4) laboratory work.
5) basal metabolism.
6) electrocardiogram.
7) diagnostic x-ray.
8) covered dental procedures which can be performed in the office.

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c. Special conditions for admissions for oral surgery or other dental services (Hospital admission for any non-emergency dental procedure requires prior authorization.)

1) Admission for Oral Surgery

a) Inpatient hospital services for recipients who require surgery by a licensed oral surgeon are covered (including payment to the surgeon) as physicians' services if the services can be performed by either a physician or dentist and only if they would constitute physicians' services when provided by a physician.

NOTE: Such services are also covered on a hospital outpatient basis and in the office.

11/01/93

b) The patient is admitted to receive the services of an oral surgeon for the removal of unerupted, impacted teeth or other dental procedures because the extent of the procedure or the patient's condition rules out surgery on other than an inpatient basis. Dental procedures must be prior-authorized.

NOTE: The above dental procedures are also covered on a hospital outpatient basis or in the practitioner's office.